STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for a State Residential Licensure Survey. June 3, 4 and 5, 2014 Facility number: 003282 Provider number: N/A AIM number: N/A Survey Team: Sandra Nolder, RN, Team Coordinator Gloria Bond, RN Census bed type: Residential: 77 Total: 77 Census payor type: Medicaid: 7 Other: 70 Total: 77 Sample: 8 These state findings are cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on June 11, 2014.	R000000	**DISCLAIMER: Preparation and implementation of this plan of correction does not constitute admission or agreement by Rittenhouse Senior Living of Indianapolis of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated June 5, 2014. Rittenhouse Senior Living of Indianapolis specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action not related directly to the licensing and/or certification of this facility or provider. Rittenhouse Senior Living respectfully requests a paper review for compliance for the annual survey.**	
R000036	410 IAC 16.2-5-1.2(k)(1-2)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on observation, interview and record review, the facility failed to notify the resident's Physicians regarding significant changes for 2 of 8 residents reviewed for significant changes. (Resident #11 and #35) Findings include: 1. Resident #11's record was reviewed on 6/5/14 at 1:22 P.M. Diagnoses included, but were not limited to, diabetes mellitus type II, hypothyroidism, dementia and depression. The resident's "Blood Glucose Monitoring Form" dated January 2014, and "Nurse's Notes" indicated the following low blood sugars lacked documentation that the Physician was notified. 1/30/14--Pre-dinner blood sugar-65. 1/31/14--Fasting blood sugar-57.	R000036	**R036 410 IAC 16.2-5-1.2(k) (1-2) Residents' Rights** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #11Call orders / parameters re: Blood sugars results requested for appropriate notification of resident physician. Resident #35 Physician was notified re: shortness of breath. Licensed Nurses for residents #11 and #35 will receive education re: the facility "Notification Policy – Physicians, Residents and Responsible Parties". 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Licensed Nurses shall receive in-service education to include	07/25/2014

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	The resident's "Blood Glucose Monitoring Form" dated February 2014, and "Nurse's Notes" indicated the following low blood sugars lacked documentation that the Physician was notified. 2/02/14--Pre-dinner blood sugar-69. 2/06/14--Pre-dinner blood sugar-53. 2/10/14--Bedtime blood sugar-64. 2/11/14-Bedtime blood sugar-68. 2/15/14--Pre-dinner blood sugar-62. 2/28/14--Bedtime blood sugar-58. The resident's "Blood Glucose Monitoring Form" dated March 2014, and "Nurse's Notes" indicated the following low blood sugars lacked documentation that the Physician was notified. 3/01/14--Bedtime blood sugar-63. 3/08/14--Pre-dinner blood sugar-52. 3/14/14--Pre-dinner blood sugar-49. 3/21/14--Bedtime blood sugar-61. 3/30/14--Bedtime blood sugar-45. The resident's "Blood Glucose Monitoring Form" dated April 2014, and "Nurse's Notes" indicated the following low blood sugars lacked documentation that the Physician was notified. 4/03/14--Pre-dinner blood sugar-63. 4/06/14--Pre-dinner blood sugar-61. 4/26/14--Bedtime blood sugar-66.		the facility policy “Notification Policy – Physicians, Residents, and Responsible Parties”. This training shall also include proper documentation in the clinical record of these notifications. Review of new orders, significant changes in resident condition contained in the twenty-four (24) hour reports will be reviewed by Resident Care Director and or their designee to ensure compliance with policy. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The results of the review of new orders, significant changes in resident condition contained in the twenty-four (24) hour reports are completed by Resident Care Director and or their designee daily Monday through Friday for four (4) weeks and one (1) time a week thereafter. Results of review will be discussed with Executive Director or their designee at weekly management meeting for ongoing compliance. 5) By what date the systemic changes will be completed: Date of completion: 7/25/14	

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	The resident's "Blood Glucose Monitoring Form" dated May 2014, and "Nurse's Notes" indicated the following low blood sugars lacked documentation that the Physician was notified. 5/01/14--Pre-dinner blood sugar-67. 5/02/14--Pre-dinner blood sugar-69. 5/06/14--Pre-dinner blood sugar-61. 5/11/14--Pre-dinner blood sugar-61. 5/12/14--Pre-dinner blood sugar-64. 5/18/14--Hypoglycemic Reaction blood sugar-56 at 3:15 P.M. 5/18/14--Hypoglycemic Reaction blood sugar--63 at 8:00 P.M. The resident's May 2014 sliding scale insulin orders lacked call parameter orders. During an interview on 6/5/14 at 3:20 P.M., the Resident Care Director (RCD) indicated the resident's sliding scale orders should have had call parameters. She indicated she would have expected the nurses to notify the Physician of a low blood sugar to get orders from the Physician. She indicated she considered a low blood sugar below 70. 2. Resident #35's record was reviewed on 6/4/14 at 10:05 A.M. Diagnoses included, but were not limited to, senile dementia, asthma, sleep apnea, debility and depressive disorder.			

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	On 6/3/14 at 10:15 A.M., Resident #35 was observed sitting in his room, facing towards the hallway door, at the end of the Reflections Unit (Dementia Unit) with a mask over his mouth and nose. He was observed receiving a nebulizer treatment (A breathing treatment medication). At 10:22 A.M., the Assistant Resident Care Director (ARCD) came into the resident's room and shut the nebulizer machine off. She took the mask off the resident and placed his glasses on his face, then left the room. The June 2014, Medication Administration Record (MAR) included, but was not limited to the following order: 5/20/14--Albuterol 0.083% Inhalation Solution (A breathing treatment medication that helped dilate the lungs to make breathing easier). Inhale 3 ml (milliliters) orally three times daily routinely. Scheduled for 8 A.M., 12 P.M. and 4 P.M. During an interview on 6/4/14 at 1:40 P.M., the Assistant RCD indicated she had given the 12 P.M., nebulizer treatment after 10 A.M., and she had signed it off on the MAR for the 12 P.M.,			

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	dose. She indicated she had given Resident #35 the 12 P.M., nebulizer treatment early due to he was short of breath. She indicated she had not notified the Physician about the resident's shortness of breath on 6/3/14 until this morning when she notified the Physician he "did not look good and required an assist of three to get him out of bed this morning." During an interview on 6/4/14 at 3:20 P.M., the RCD indicated the ARCD should have notified the Physician on 6/3/14 regarding his shortness of breath to get an order to give the scheduled 12 P.M., nebulizer treatment early. During an interview on 6/5/14 at 4:10 P.M., the ARCD indicated she did not document the resident's shortness of breath or called to notify the Physician on 6/3/14 of the resident's change in condition and she should have documented and called. A current policy dated 4/30/2008, provided by the RCD on 6/5/14 at 9:34 A.M., titled "3.7 Observation and Recording" indicated, "...Process: 2. All staff is responsible for recording any significant change or problems, either observed or reported by the resident, in the resident's medical record...."			

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	A current policy dated 8/20/2008, provided by the RCD on 6/5/14 at 9:34 A.M., titled "Notification Policy-Phyicians, Residents, Responsible Parties" indicated, "...Process: ... Steps: 2.1 Upon report of or observance of a change of condition immediately assess the resident's condition; physical, mental or psychosocial to determine if there is a significant change. 2.2 Notify the resident's physician of the change in condition noted. Follow instruction/orders received from the physician and begin any treatment requested...."			

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R000092	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			

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	Based on interview and record review, the facility failed to show documentation that they attempted to hold a fire and disaster drill in conjunction with the local fire department at least every six months. This deficiency had the potential to affect all 77 residents residing in the facility. Findings include: A record review of the facility's fire drills for the last year was reviewed on 6/3/14 at 4 P.M. The monthly fire drill documentation lacked evidence that the facility had attempted a fire and disaster drill in conjunction with the local fire department at least every six months. During an interview on 6/4/14 at 11:30 A.M., the Maintenance Director indicated the facility had not attempted a fire and disaster drill in conjunction with the local fire department at least every six months that he knew about. He indicated he had taken this position in April 2014, and before that he was a maintenance assistant. He indicated he was not aware these drills had to be attempted in conjunction with the fire department.	R000092	**R 092 410 IAC 16.2-5-1. 3(i) (1-2) Administration and Management** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected. The facility will document the attempts to hold a fire and disaster drill in conjunction with the local fire department at least every six (6) months. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The facility will document the attempts to hold a fire and disaster drill in conjunction with the local fire department at least every six (6) months 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The facility Maintenance Director or their designee, will review scheduled fire drills, where facility has contacted local fire department in their attempts to hold a semi-annual fire and disaster drills in conjunction with the local fire department, at facility's safety	07/25/2014

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			meetings. 5) By what date the systemic changes will be completed: Date of completion: 7/25/14	
R000093	410 IAC 16.2-5-1.3(j)(1-4) Administration and Management - Noncompliance (j) If professional or diagnostic services are to be provided to the facility by an outside resource, either individual or institutional, an arrangement shall be developed between the licensee and the outside resource for the provision of the services. If a written agreement is used, it shall specify the following: (1) the responsibilities of both the facility and the outside resource; (2) the qualifications of the outside resource staff; (3) a description of the type of services to be provided, including action taken and reports of findings; and (4) the duration of the agreement. Based on interview and record review, the facility failed to ensure laboratory tests were obtained for 2 of 4 residents reviewed for laboratory test results. (Residents #11 and #35) Findings include: 1. Resident #11's record was reviewed on 6/5/14 at 1:22 P.M. Diagnoses included, but were not limited to, diabetes mellitus type II, hypothyroidism, hyperlipidemia and depression. A Physician order dated 1/23/14,	R000093	**R 093 410 IAC 16 .2-5-1 .3(i) (1-4) Administration and Management** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Labs: Resident #11: Lab orders and results given for this resident for ALT test. Resident #35: Lab orders and results were given for this resident for CBC with differential, Hgb A 1C, PSA, TSH, Vitamin D level, B12 level and prealbumin. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice	07/25/2014

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	indicated "Order clarification: Routine labs of ALT [Alanine Aminotransferase] [A laboratory test that measured for liver disease], TSH [Thyroid Stimulating Hormone] [A laboratory test that measured the thyroid gland function], + [and] Lipid panel [A laboratory test that measured liver function] In 8 weeks. Scheduled Date-3/12/14." The resident's record lacked ALT laboratory results for 3/12/14. During an interview on 6/5/14 at 4:15 P.M., the Resident Care Director (RCD) indicated she had called the Laboratory to get the results for the ALT test and the laboratory test had not been drawn. She indicated the lab would be drawn tomorrow. 2. Resident #35's record was reviewed on 6/4/14 at 10:05 A.M. Diagnoses included, but were not limited to, diabetes mellitus, debility, hypertension, hyperlipidemia, history of edema, and asthma. A Physician's order dated 5/16/14, indicated CBC (complete blood count) with differential (A laboratory test to test for infection and blood loss), CMP (complete metabolic panel) (A laboratory test that tested kidney and liver function),		and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The facility will implement lab tracking system to ensure the timely completion of requested lab orders. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Resident Care Director and or their designee will monitor the lab tracking system daily Monday through Firday for four (4) weeks and one (1) time a week thereafter, to ensure the timely completion of requested lab orders. The results of the monitoring tool will be discussed/ reviewed with the Executive Director or their desginee at the weekly management meeting for compliance. 5) By what date the systemic changes will be completed: Date of completion: 7/25/14	

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	Hgb A1C (Hemoglobin A1C) (A laboratory test that checked compliance of diabetics), PSA (Prostate Specific Antigen) (A laboratory test that checked for prostate cancer), Vitamin D OH level, B12 (Vitamin B12) level and Prealbumin (A laboratory test that checked for malnutrition). The resident's record lacked laboratory results for the CBC with differential, Hgb A1C, PSA, TSH, Vitamin D level, B12 level and prealbumin. During an interview on 6/5/14 at 9:10 A.M., the RCD indicated she had contacted the Laboratory to get the test results and the laboratory tests for the CBC with differential, Hgb A1C, PSA, TSH, Vitamin D level, B12 level and prealbumin were not drawn when the CMP was drawn, but she was having them drawn today.			
R000117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number,			

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	qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview the facility failed to ensure there was a CPR (cardiopulmonary resuscitation) and first aid certified staff member in the facility available for residents at all times. This had the potential to affect all 77 residents currently living in the facility. Findings include: Record review of employee records was completed on 6/5/2014 at 3:20 P.M. The employee CPR and First Aid certifications were reviewed. The record for the Nursing and CNA (Certified Nursing Assistant) schedule as worked for the past week was provided	R000117	**R 117 410 IAC 16.2-5-1.4(b) Personnel** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected. The facility completed CPR and First aid training on 6/17/14, to ensure that employees have received CPR/ First aid training. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3). What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The	07/25/2014

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	by the RCD (Resident Care Director) on 6/5/2014 at 3:35 P.M. The two records were compared and the following was found: On 5/31/14 for the 2 P.M. to 10 P.M., shift no staff had current CPR and First Aid certification. On 5/31/14 for the 10 P.M. to 6 A.M., shift no staff had current CPR and First Aid certification. On 6/1/14 for the 2 P.M. to 10 P.M., shift no staff had current CPR and First Aid certification. On 6/1/14 for the 10 P.M. to 6 A.M., shift no staff had current CPR and First Aid certification. On 6/3/14 for the 10 P.M. to 6 A.M., shift no staff had current CPR and First Aid certification. In an interview with the RCD on 6/5/2014 at 3:55 P.M., she indicated the current CPR and First Aid certifications with staff was something she was aware needed checked.		facility will ensure at least one current nursing staff, on each shift, will have completed CPR and first aid training prior to scheduling duties. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The facility will review the monthly master schedule and the current CPR/ first aid completed training of all licensed staff, scheduled to work, to ensure compliance. Results of review will be discussed with Executive Director or their designee, at weekly management meeting for compliance. 5) By what date the systemic changes will be completed: Date of completion: 7/25/14	
R000119	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the			

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	employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on record review and interview the facility failed to instruct each employee in orientation of dementia care. This deficiency had the potential to affect 22 residents in the secured dementia unit and any of the 55 residents in the un-secured area showing signs of dementia residing in the facility. Findings include:	R000119	**R 119 410 IAC 16.2-55-1. 4(d)(1)(A-E)(2)(A-D)(3-) Personnel** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected. The facility will have staff with completed dementia training caring for residents in the secured area and unsecured area of the facility. 2) How the facility	07/25/2014

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	Record review of employee records was completed on 6/5/2014 at 3:20 P.M. The record was reviewed for dementia care training for 8 employees. Only 2 of the 8 employees had dementia care training. One was the MCD (Memory Care Director) and the other was the DDS (Director of Dining Services). In an interview with the Administrator on 6/5/14 at 3:20 P.M., she indicated dementia training had been very sporadic and just recently they started doing the training with the focus on the staff in the dementia care area first.		will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3). What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The facility will ensure current staff will receive or have documented evidence of receiving dementia training. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The facility will review at weekly management meeting with Executive Director or their designee, the staff listing with current dementia training completed, to ensure staff have received dementia training to ensure compliance. 5) By what date the systemic changes will be completed: Date of completion: 7/25/14	
R000148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued			

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	upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview and record review, the facility failed to have the heating and ventilating systems inspected annually and 2 of 2 main laundry dryer lint filters had lint buildup. This deficiency had the potential to affect all 77 residents residing in the facility. Findings include: 1. A record review of a job invoice from [name of company] dated 8/24/12, provided by the Maintenance Director on 6/4/14 at 12:19 P.M., indicated "Performed routine maintenance was performed on 11 condensing units [air conditioning units] and 13 air handlers [heating system units] for both cooling and heating cycles...." During an interview on 6/4/14 at 11:30 P.M., the Maintenance Director indicated the heating and ventilating systems had not been inspected annually that he knew about. He indicated he was not certified	R000148	**R148 410 IAC 16.2-5-.5(e) (1-4) Sanitation and Safety** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A.The facility will contract with a qualified outside provider to annually inspect the heating and ventilation systems. All residents have the potential to be affected. B .Lint filters in dryers were immediately cleaned. Staff in serviced on compliance with cleaning lint filters. All residents have the potential to be affected. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: A. The heating and ventilation systems will be inspected annually as indicated on the service agreement with the qualified	07/25/2014

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	or specifically trained to inspect the equipment annually. 2. During the environmental tour on 6/4/14 at 11:20 A.M., with the Maintenance Director in attendance, the main laundry room right sided dryer was observed to have had resident's clothes sitting in it. The lint filter under the dryer drum was observed covered with white lint. The Maintenance Director used his right hand and wiped his four fingers across the lint filter and had lint balled up on his fingers. The area of the filter that he had wiped was clean. The left side of the dryer was observed to have had a load of towels that were being dried. On 6/5/14 at 9:50 A.M., with the Administrator in attendance both main laundry room, both dryers were observed with the lint filters under the dryer drum covered with white lint. During an interview on 6/4/14 at 11:20 A.M., the Maintenance Director indicated the lint filter was to be cleaned "after" every load of laundry. He indicated the CNA's signed a sheet of paper when they cleaned the filter to indicate it had been cleaned. A document hanging on a clipboard by the right side dryer titled, "Yes I cleaned		outside provider. B. Maintenance and or their designee will check dryers daily Monday through Friday for four (4) weeks and one (1) time a week thereafter, for compliance with the cleaning of lint filters. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A. The Executive Director will review the annual inspection of the heating and ventilation systems for compliance and report results of review at facility's Safety Meeting. B. The Executive Director or their designee will review the monitoring tool for daily dryer cleaning checks at weekly management meeting for compliance. 5) By what date the systemic changes will be completed: Date of completion: 7/25/14	

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	the lint filter in the Dryer" indicated "(please note date you cleaned lint filter, check each time you put in a load to dry)." The document was signed with a signature on these lines for the date of 6/2 for the 6 A.M. to 2 P.M. shift and 6/3 for the 6 A.M. to 2 P.M. The document had no other signatures at this time. During an interview on 6/4/14 at 5:10 P.M., the Administrator indicated the 2 P.M. to 10 P.M., shift CNA's gathered the laundry, the 10 P.M. to 6 A.M., shift CNA's did the laundry and the 6 A.M. to 2 P.M., shift CNA's delivered the laundry. She indicated all shifts did the laundry as needed if resident's had incontinent episodes. During an interview on 6/5/14 at 9:50 A.M., the Administrator indicated both the main laundry room dryer lint filters needed to be cleaned. She indicated when she looked back at the April 2014 and May 2014, lint filter documentation sheets that evenings and midnights have not been signing the forms, which could indicate the filters were not cleaned before a load of laundry was placed into the dryer.			

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R000154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview and record review, the facility failed to maintain a clean freezer, and oven and to label food items in the freezer. This deficiency had the potential to affect all 77 residents currently receiving food from the kitchen. Findings include: On 6/3/14 at 9:35 A.M., a sanitation and safety tour of the kitchen was started with FSA (Food Service Assistant) #1 in attendance. He indicated he was one of the cooks. During the initial tour, Freezer #1 was observed packed with food items up to the door. On the top shelve was a large number of bagged food items in clear plastic bags. Some had dates that were faded and hard to read, but did not have a label indicating what food was in the bag. On the top shelve was also a bag of what looked to be waffles tightly packed next to what looked like meat. The waffles	R000154	**R154 410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A.The Dietary staff removed all unlabeled and undated food items that were identified during the survey. All residents have the potential to be affected. B .The inside of oven and freezer were cleaned during survey. All residents have the potential to be affected. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: A. Dietary staff was re- in-serviced on Labeling Policy. B. Dietary staff was re-in-serviced on compliance with cleaning schedule and Monitoring kitchen sanitation. 4) How the	07/25/2014

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	were not dated or labeled in any way. On one of the middle shelves a bottle of what was observed to be dark frozen soda pop was on the shelve. There was also a paper like bag observed with food items sticking out of it. No identification of the food item or a date was observed on the bag. The bottom lip of the freezer was observed with food residue. In an interview with FSA #1, at this time, he indicated as he took one of the bags out, that it looked to him like it was most likely containing chicken fingers. The food item sticking out of the paper bag he identified as sweet potato fries. He had no explanation for the frozen soda pop or the general condition of the freezer. Record review of the facility's labeling policy was conducted on 6/4/14 at 3:25 P.M., of the facility's record titled: "Date Marking." The record indicated, "Expiration dates: Is the date with which the manufacturer guarantees the food will meet its quality standards. Date marking for discard ensures the safety of the food...." On 6/3/14 at 9:45 A.M., during the sanitation and safety tour of the kitchen, the inside of the oven door was observed to have food residue covering part of it.		corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A. Dietary Services manager and or their designee will do daily audits Monday through Friday for four (4) weeks and one (1) time a week thereafter. The consultant RD will do every other month audits of compliance (ongoing per contract) with food labeling policy. B. The Dietary Services Manager and or their designee will review the results of their audit with Executive Director or their designee at weekly management meeting for compliance. 5) By what date the systemic changes will be completed: Date of completion: 7/25/14	

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	During an interview with the DDS (Director of Dining Services) on 6/4/14 at 3:30 P.M., she indicated waffles should not be next to the meat and items should be labeled. She indicated the freezer was in need of cleaning. The oven is suppose to be wiped daily and deep cleaned once per month.			
R000214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate the individual needs of residents related to significant changes in conditions and updated Service Plans for 5 of 8 residents reviewed for Service Plans . (Residents #9, #11, #35, #59 and #96) Findings include: 1. Resident #11's record was reviewed on 6/5/14 at 1:22 P.M. Diagnoses included dementia, diabetes mellitus type	R000214	**R214 410 IAC 16.2-5-2(a) Evaluation** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Service Plans for: Resident #11: Service plan updated to reflect significant change in current resident condition. Resident #35 Service plan updated to reflect significant change in current resident condition. Resident# 59 Service plan updated to reflect significant change in current resident condition. 2) How the facility will identify other residents having	07/25/2014

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	II, depression and anxiety. The resident's current "Six Month Care Plan Review" dated 1/24/14, the "Continence" area indicated, the resident was continent of bowel and bladder. The "Physical Health" area indicated the resident's blood sugars fluctuated and she was non-compliant with her diet frequently. The current "Six Month Care Plan Review" lacked documentation of the resident's significant change of conditions. The resident had been treated with antibiotics for a urinary tract infection, a tooth abscess and had a tooth extraction since 1/28/14. During an interview on 6/5/14 at 3:20 P.M., the Resident Care Director (RCD) indicated she had not updated the resident's "Service Plan" or completed new evaluations for the resident's urinary tract infection, tooth abscess or tooth extraction. 2. Resident #35's record was reviewed on 6/4/14 at 10:05 A.M. Diagnoses included, but were not limited to, senile dementia, asthma, sleep apnea, chronic pain, depressive disorder and debility. The resident's current "Six Month Care		the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: The Service Plans for all residents shall be audited to ensure the Service Plan addresses resident needs, preferences, current physician orders, specific medical requirements and **significant changes in condition.** 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Service Plans for all residents shall be audited by the Resident Care Director and or their designee, daily Monday through Friday for four (4) weeks and one (1) time a week thereafter, to ensure the Service Plan addresses resident needs, preferences, current physician orders, specific medical requirements and **significant changes in condition.** Review of the twenty-four hour report (change in condition) and new orders will be used to update if appropriate the current resident service plan. Results of the audit will be discussed with Executive Director or their designee at weekly management meeting to	

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	Plan Review" dated 10/2/13, indicated the resident's "Nutritional Status" area indicated the resident was on a regular diet. The "Medication Administration/Pain Control" area indicated he was not currently on routine medications. The "Physical Health" area indicated the resident's health was currently stable. The resident's current "Six Month Care Plan Review" lacked documentation of significant changes. The resident was currently being treated for a cough with audible wheezing with nebulizer treatments, and he had a 9 pound weight loss in February 2014. During an interview on 6/4/14 at 1:40 P.M., the RCD indicated she should have placed the resident's significant changes related to his weight loss and the cough being treated with nebulizer treatments on the "Service Plan". 3. Resident #59's record was reviewed on 6/4/14 at 12:13 P.M. Diagnoses included, but were not limited to dementia, atrial fibrillation osteoporosis, anemia, hypertension, and mitral regurgitation. The resident's current "Six Month Care Plan Review" dated 5/20/14, indicated		ensure compliance. 5) By what date the systemic changes will be completed: Date of Completion: 7/25/14	

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	the "Medication/Administration/Pain Control" area indicated the staff administered all her medications, and "Behavioral/Mood Patterns" indicated Xanax (An antianxiety medication) -twice, Zyprexa (An antipsychotic medication)-once, Remeron (An anti-depressant medication)-once and Lexapro (An anti-depressant)-once. The "Physical Health" area indicated the resident's oxygen saturation after ambulating 200 feet will be 80% and while seated in the wheelchair will be 90%. The resident's current "Six Month Care Plan Review" dated 5/20/14, lacked documentation of significant changes. The resident was sent to the Emergency Room for a large laceration to her left forearm that was self inflicted, then she was admitted to the Psychiatric unit due to harming herself. The resident had a chest X-ray dated 5/12/14, that indicated she had and early infiltrate (possible start of pneumonia) in the right lung base. She had been placed on Clindamycin (An antibiotic medication), oxygen at 2 liters via nasal cannula, mechanical soft diet, and Speech Therapy for dysphagia on 5/13/14. During an interview on 6/4/14 at 3:20 P.M., the RCD indicated she should have			

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	updated the resident's "Service Plan" with the significant changes of conditions. 4. Resident #96's record was reviewed on 6/5/14 at 10:00 A.M. Diagnoses included, but were not limited to, anxiety disorder, depressive disorder, dementia, and osteoporosis. The resident's current "Six Month Care Plan Review" updated 8/1/13, indicated the "Cognitive Patterns" area indicated the resident was alert to her surroundings. The "Behavioral/Mood Patterns" indicated the resident was forgetful and would ask questions repetitively, easily redirected, had more anxiety, took a lot of staff interventions and redirections from staff and utilized a wanderguard (a bracelet with a box on it that prevents the resident from wandering out of the facility without staff knowledge). The "Other" area indicated the resident had a wanderguard tag due to she was at high risk for elopement (exiting the facility without staff knowledge). The resident's current "Six Month Care Plan Review" updated 8/1/13 lacked documentation of significant changes. The resident was being monitored for confusion, wandering, and unusual behaviors. She had been on 15 minute and 30 minute checks for her safety. She			

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RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

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	had been exit seeking at the front door and had gotten to the employee door exit seeking looking for her either her car, granddaughter, or son. She was treated with Levaquin (An antibiotic medication) for 5 days starting on 2/4/14 for a urinary tract infection, and she had been treated by a Psychiatrist for behavioral health issues. She was treated for a urinary tract infection with Septra (An antibiotic medication) for 7 days starting 4/24/14. During an interview on 6/5/14 at 3:20 P.M., the RCD indicated the resident's "Service Plan" should have been updated with the significant changes. A current policy dated 1/1/2010, provided by the Administrator on 6/5/14 at 10:50 A.M., titled "Care Plan and Service Plan Guidelines for Care 1.1" indicated, "Care Plan 1.0: 1.1 An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually, upon a known substantial change in the resident's condition, upon resident or facility request...."5. Resident #9's record was reviewed on 6/3/2014 at 3 P.M. Diagnoses included, but were not limited to history of pelvic fracture, history of radius/ulna fracture (wrist fracture), dermatosis, depression, hypothyroidism and history of UTI			

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	(urinary tract infection). An admission nursing assessment was completed on 10/23/2013 and another one was completed on 4/1/14. The resident's record titled "Six Month Care Plan Review" and dated 11/22/13 indicated, " Cognitive Patterns alert, oriented x 3; Communication Ability speech clear. No difficulty understanding, utilizes call pendent...." During an interview on 6/4/14 at 10:00 A.M., with the RCD (Resident Care Director), she indicated this, "Six Month Care Plan Review" was the resident's service plan. She indicated she did not know she had to put what services were being provided and by whom on the service plans. In an interview with the RCD and the Administrator on 6/4/14 at 10:00 A.M., they indicated they would check into what their "sister facilities" used for service plans to use. They indicated that at this time they just had the, "Care Plan Review" as their,"Service Plans." The nurse's notes dated 1/27/14 at 1 P.M., "res [resident] found on floor in dining room in sitting position [symbol for with] [symbol for no] pain, a			

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	laceration to [symbol for left] middle finger the whole width of knuckle. Order to send to ER [Emergency Room] for eval [evaluation]..." The nurse's notes dated 1/27/14 at 8 P.M., indicated," notified ...resident is being admitted [symbol for with] multiple pelvic fx [fracture], fx wrist and fx thumb..." The record lacked an updated, "Service Plan" after the resident's hospitalization. At exit on 6/5/14 at 6:20 P.M., no further information was provided by the facility.			
R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview and record review, the facility failed to supervise a medication administration of a nebulizer treatment for 1 of 7 residents observed receiving a nebulizer treatment. (Resident #35) Findings include:	R000241	**R 241 410 IAC 16.2-5-4 (e) (1) Health Services** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Supervision during Medication Administration/ Nebulizer for: Resident #35: Is supervised during his medication administration/ Nebulizer Treatment. Licensed nurse,	07/25/2014

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	On 6/3/14 at 10:15 A.M., Resident #35 was observed sitting in his room, facing towards the hallway door, at the end of the Reflections Unit (Dementia Unit) with a mask over his mouth and nose. He was observed receiving a nebulizer treatment (A breathing treatment medication), without any observed staff member in attendance. He had his right hand on the mask at the nose area. At 10:22 A.M., the Assistant Resident Care Director (ARCD) came into the resident's room and shut the nebulizer machine off. She took the mask off the resident and placed his glasses on his face, then left the room. At 10:25 A.M., the ARCD came back into the resident's room and transported him into the activity room to join an activity. The resident's record was reviewed on 6/4/14 at 10:05 A.M. Diagnoses included, but were not limited to, senile dementia, asthma, sleep apnea, debility and depressive disorder. The June 2014, Medication Administration Record (MAR) included, but was not limited to the following order: 5/20/14--Albuterol 0.083% Inhalation		identified during survey, was educated on the policy for Nebulizer treatments. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Licensed nursing staff was educated the policy and procedure for Nebulizer Treatments. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Resident Care Director or their designee will complete an observation report weekly for four (4) weeks and one (1) time a month thereafter. The result of this observation report for the performance of the medication administration policy (nebulizer treatments) will be discussed with the Executive Director or their designee, during weekly management meeting for ongoing compliance. 5) By what date the systemic changes will be completed: Date of Completion: 7/25/14	

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	Solution (A breathing treatment medication that helped dilate the lungs to make breathing easier). Inhale 3 ml (milliliters) orally three times daily routinely. Scheduled for 8 A.M., 12 P.M. and 4 P.M. During an interview on 6/4/14 at 1:40 P.M., the ARCD indicated she had given the resident his 12 P.M., nebulizer treatment after 10 A.M., and she had signed it off on the MAR for the 12 P.M. dose. She indicated she had 90 minutes before and after a scheduled medication to give that medication to be in compliance. She indicated she left the residents diagnosed with dementia alone with a nebulizer treatment being administered because she looked at her watch when she started the treatment, then she came back when the treatment should be done in approximately 15 to 20 minutes. She indicated she had given Resident #35 the 12 P.M., nebulizer treatment early due to he was short of breath and had left him alone during the treatment after being short of breath to accept a phone call. During an interview on 6/4/14 at 3:20 P.M., the Resident Care Director (RCD) indicated the ARCD should have stayed with the resident during the entire nebulizer treatment. She indicated the			

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	nurses have an hour before and after the scheduled medication time to administer the medication. A current policy dated 4/30/2008, titled "8.6 Medication Administration : General Guidelines" indicated, "Process: ...12. Administer medications in accordance with physician's order. 13. All current medications and dosages schedules are listed on the resident's medication record...14. Unless otherwise specified by the health care provider, administer routine medications according to the established medication administration schedule for the Assisted Living Community and agreed upon by the resident...15. Medications are taken within one hour of the scheduled time except when ordered before, with or after meals...." A current policy dated 11/15/2010, titled "Nebulizer Medications: Observation" indicated, "Policy: Observation and assessment of the resident prior to, during and following a nebulizer treatment is conducted by licensed nursing staff...."			

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R000242	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on observation, interview and record review, for 1 resident observed receiving a nebulizer treatment out of 6 residents listed as residents who received nebulizer treatments the facility failed to monitor for adverse effects of a medication during the administration of a nebulizer treatment. (Resident #35) Findings include: On 6/3/14 at 10:15 A.M., Resident #35 was observed sitting in his room, facing towards the hallway door, at the end of the Reflections Unit (Dementia Unit)	R000242	**R 242 410 IAC 16.2-5-4 (e) (2) Health Services** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Assessment during Medication Administration/ Nebulizer for: Resident #35: Is being monitored during his medication administration/ Nebulizer Treatment. Licensed nurse, identified during survey, was educated on the policy for Nebulizer treatments. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective	07/25/2014

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	with a mask over his mouth and nose. He was observed receiving a nebulizer treatment (A breathing treatment medication) without any observed staff member in attendance. He had his right hand on the mask at the nose area. At 10:22 A.M., the Assistant Resident Care Director (ARCD) came into the resident's room and shut the nebulizer machine off. She took the mask off the resident and placed his glasses on his face, then left the room. At 10:25 A.M., the ARCD came back into the resident's room and transported him into the activity room to join an activity. The resident's record was reviewed on 6/4/14 at 10:05 A.M. Diagnoses included, but were not limited to, senile dementia, asthma, sleep apnea, debility and depressive disorder. The June 2014, Medication Administration Record (MAR) included, but was not limited to the following order: 5/20/14--Albuterol 0.083% Inhalation Solution (A breathing treatment medication that helped dilate the lungs to make breathing easier). Inhale 3 ml (milliliters) orally three times daily		action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Licensed nursing staff was educated the policy and procedure for Nebulizer Treatments. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Resident Care Director or their designee will complete the observation report weekly for four (4) weeks, then one (1) time a month thereafter. The results of this observation report for the performance of the medication administration (assessment during nebulizer treatments) will be discussed with the Executive Director or their designee during weekly management meeting for ongoing compliance. 5) By what date the systemic changes will be completed: Date of Completion: 7/25/14	

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	routinely. Scheduled for 8 A.M.,12 P.M. and 4 P.M. During an interview on 6/4/14 at 1:40 P.M., the ARCD indicated, she left the residents diagnosed with dementia alone with a nebulizer treatment being administered because she looked at her watch when she started the treatment, then she came back when the treatment should be done in approximately 15 to 20 minutes. She indicated she assessed the resident's temperature, oxygen saturation (amount of oxygen in the blood) and lung sounds before and after each treatment, but she did not document her assessments anywhere for scheduled treatments. She indicated after the nebulizer treatment was administered on 6/3/14, she assessed the resident's oxygen saturation, but no vital signs or lung sounds. During an interview on 6/4/14 at 3:20 P.M., the RCD indicated she expected the ARCD to assess the residents according to the nebulizer treatment policy and procedure. A current policy dated 11/15/2010, provided by the Administrator on 6/4/14 at 2:45 P.M., titled "Nebulizer Medications: Observation" indicated, "Policy: Observation and assessment of the resident prior to, during and			

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	following a nebulizer treatment is conducted by licensed nursing staff... Purpose: To promote resident health and independence through early detection of, and attention to respiratory issues, and any adverse effects and health conditions related to the treatment administered. Process: 1. Prior to and following administration of inhaled nebulizer medications, licensed nursing will observe resident respirations; check O2 [oxygen] sats [saturations], pulse and auscultate lungs, including whether...2. Observe the resident's skin color for evidence of inadequate oxygen supply...." A current policy dated 4/30/2008, provided by the Resident Care Director (RCD) on 6/4/14 at 11:00 A.M., titled "8.6 Medication Administration : General Guidelines" indicated, "...Process:... 21. Observe the resident for potential adverse effects of medications (s) taken...22. Observe the resident for significant changes in health or behavior which may necessitate a change in medication...."			

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure a sanitary environment in the food preparation areas of the kitchen. A cook had no hair covering on, maintenance personnel had no hair covering on and changed a kitchen overhead light while	R000273	**R 273 410 IAC 16.2-5-5.1 (f) Food and Nutritional Services** 1) What corrective action(s) will be	07/25/2014

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	food was out and being prepared. This deficiency had the potential to affect all 77 residents currently receiving food from the kitchen. Findings include: During an initial kitchen observation on 6/3/14 at 9:55 A.M., FSA (Food Service Assistant) #1 who identified himself as one of the cooks was observed without hair covering. He indicated at the time he knew he was suppose to wear a hair covering but the hair coverings would fly off when he opened the oven door. He indicated there were other hair nets available. On 6/3/14 at 11:15 A.M., in a second kitchen observation, the Maintenance Director was observed changing a light fixture with no hair net on and during the active preparation of food near by. During an interview with the DDS (Director of Dining Services) on 6/4/14 at 3:30 P.M., she indicated hair coverings were to be worn in the kitchen and she was disappointed in the staff members that were observed not wearing hair coverings in the kitchen. She indicated that maintenance should not be changing over head light fixtures and doing non-essential work during food		accomplished for those residents found to have been affected by the deficient practice: Hair Coverings for: A. The staff member/Cook identified during survey, immediately complied with the hair covering policy. Dietary staff were in serviced on Hair Covering policy. The staff member (cook) received a corrective action for non-compliance with hair covering policy B. Maintenance Personnel: Maintenance and Housekeeping personal received in-service education on hair covering policy. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected.	

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	preparation time when food is out. The record of the facility's dietary policies and procedures was reviewed on 6/4/14 at 3:45 P.M. The record dated 3/6/14 and titled: "Dietary Policies and Procedures" indicated, "All [name of facility] employees preparing food, as well as all individuals entering food preparation areas, shall have their hair covered in a proper manner at all times. Purpose to ensure a sanitary environment in areas directly effecting the preparation of food items...."		3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Dietary staff educated/ in-serviced on hair covering policy. Dietary Services Director and or their designee will completed the Dietary Sanitation checklist section: Employees: Hair restraints used properly weekly. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Dietary Services Director and or their designee will completed the Dietary Sanitation checklist section: Employees: Hair restraints used properly weekly. Results of checklist will be reviewed at weekly management meeting.	

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			5) By what date the systemic changes will be completed: Date of Completion: 7/25/14	
R000306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to document in the resident's clinical record the disposition of a resident's medications for 1 of 2 resident's reviewed for disposition of medications on discharge. (Resident #41).	R000306	**R306 410 IAC 16.2-5-6(g) (1-9) Pharmaceutical Services** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Disposition of Medications Resident #41: Family member of discharged resident #41 was contacted and	07/25/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Resident #41's record was reviewed on 6/3/14 at 1:30 P.M. Diagnoses included, but was not limited to, chronic back pain, diabetes, Alzheimer's dementia, hypothyroidism, depression and history of c-diff (Clostridium Difficile-a bowel infection). Resident's nurses notes indicate on 2/4/14, "Res [resident] very lethargic BS[blood sugar] 504...Res transferred[sic] to hospital...res was admitted for dehydration..." On 3/25/14 the nurse's note indicated, "Res expired at [name of the facility]" On 4/1/14 the nurse's note indicated, "Res property picked up by family, release of property signed." The resident's record lacked information regarding the disposition of the resident's medications. Records were requested at this time. As of exit on 6/5/14 at 6:20 P.M., no records were provided that indicated what happened to the resident's medications.		verbally verified the disposition of medications. Licensed Nurses received in-service education to include the "Policy on Disposition of Medications" 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: All discharged medical charts will be audited to ensure proper documentation of the disposition of medication. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Discharge Resident checklist will be used to monitor compliance with disposition of medications. Resident Care Director and or their designee will review Discharge Resident Checklist weekly for four (4) weeks then one (1) time a month thereafter. The results of the review of the Discharge Resident Checklist will be discussed with Executive Director or their designee during weekly management meeting for compliance. 5) By what date the systemic changes will be completed: Date of Completion: 7/25/14	

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		A. BUILDING 00 B. WING	06/05/2014

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R000354	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure interfacility transfer documentation was completely documented for 2 of 5 residents reviewed for interfacility transfers. (Residents #9 and #59) Findings include: 1. Resident #59's record was reviewed on 6/4/14 at 12:13 P.M. Diagnoses included dementia, atrial fibrillation, insomnia, and anemia.	R000354	**R354 410 IAC 16.2-5-8.1 (g) (1-7) Clinical Records** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Transfer Records Resident #9: Was transferred in an urgent status and documentation not transcribed on the Transfer Form was included in her transfer packet. Resident #59: Was transferred in an urgent status and documentation not transcribed on the Transfer Form was included in her transfer packet. Licensed Nurses shall receive in-service education to	07/25/2014

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	A "Patient Transfer Form" indicated the resident was being transferred to [name of hospital] on 4/17/14. This form lacked the following information: The location of the resident's personal property when transferred to the acute care facility, functional abilities and physical limitations of the resident and an updated list of the resident's Physician ordered medications and when they were last administered. The dates of her last chest X-ray and tuberculin skin test. The transferring nurse had not signed or dated the transfer form. During an interview on 6/4/14 at 3:20 P.M., the Resident Care Director indicated she had expected the nurse that transferred the resident to the receiving facility to have filled the transfer form out with the required information, signed and dated the form.2. Resident #9's record was reviewed on 6/3/14 at 3 P.M. Diagnoses included, but were not limited to, CVA (cerebral vascular accident or stroke), memory disorder, and high blood pressure. The resident's record indicates under nurse's notes for 1/27/14 at 1 P.M., "res [resident] found on floor in dining room in sitting position [symbol for with] [symbol for no] pain, a laceration to [symbol for left] middle finger the whole		include the proper completion of Transfer/ Discharge documentation. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Licensed Nurses shall receive in-service education to include the proper completion of Transfer/ Discharge documentation. Discharging nurse will indicate on twenty-four hour report, proper completion of transfer documentation. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Resident Care Director and or their designee will review the transfer forms for proper completion weekly for four (4) weeks then one (1) time a month thereafter. The results of the review will discuss with Executive Director or their designee at weekly management meeting for ongoing compliance. 5) By what date the systemic changes will be completed: Date of Completion: 7/25/14	

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	width of knuckle. Order to send to ER [Emergency Room] for eval [evaluation]...." The resident's nurse's notes dated 1/27/14 at 8 P.M., indicated,"notified ...resident is being admitted [symbol for with] multiple pelvic fx [fracture], fx wrist and fx thumb...." Resident #9's transfer form contained only the resident's name, current address and vital signs. The transfer form lacked the name of the receiving institution, notes relating to the resident's diagnoses at time of transfer, functional abilities and physical limitations, medications, treatments, diet, date of chest x-ray and skin test for tuberculosis. During an interview with the RCD(Resident Care Director) on 6/5/14 at 3:30 P.M., she indicated how much information is filled out on the transfer forms varied.			
R000410	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read,			

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	and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to ensure 3 of 6 residents received a first or second step tuberculin skin test prior to or upon admission to the facility. (Residents #11, #35 and #59) Findings include: 1. Resident #11's record was reviewed on 6/5/14 at 1:22 P.M. Diagnoses included, but were not limited to, diabetes mellitus Type II, dementia, depression and anxiety. The "Nursing Admission Assessment" dated 9/4/13, indicated the resident was admitted to the facility on 9/4/13. The "Resident TB/Immunization Record" indicated the first step tuberculin test was	R000410	**R410 410 IAC 16.2-5-12 (e) (f) (g) Infection Control** 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: TB Testing? Resident #11: First and second step Tuberculin skin test was re-administered. Resident #35: First and second step Tuberculin skin test was re-administered Resident #59: First and second step Tuberculin skin test was re-administered Licensed Nurses shall receive in-service education to include the “Policy on Infection Control re: TB Testing” 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility	07/25/2014

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	placed on 9/4/13. The "Resident TB/Immunization Record" lacked documentation of a second step tuberculin skin test. During an interview on 6/5/14 at 4:15 P.M., the Resident Care Director (RCD) indicated the resident did not receive a second step tuberculin skin test completed prior to or upon admission. She indicated her first and second step tuberculin skin tests were being re-administered as of today. 2. Resident #35's record was reviewed on 6/4/14 at 10:05 A.M. Diagnoses included, but were not limited to, senile dementia, asthma, depressive disorder, diabetes mellitus and debility. The "Resident TB/Immunization Form" indicated the resident was admitted to the facility on 9/27/13. The "Resident TB/Immunization Form" indicated the first step tuberculin skin test was completed on 9/30/13. During an interview on 6/5/14 at 9:10 A.M., the RCD indicated there was no other tuberculin skin test documentation found for the resident other than the 9/30/13 tuberculin skin test. She indicated he did not get a tuberculin skin		will make to ensure that the deficient practice does not recur: Admitting nurse will utilized the admission checklist to ensure TB Testing completed, per policy and recorded on medication administration record. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Resident Care Director and or designee will review admission checklist weekly for four (4) weeks then one (1)time a month thereafter. The results of the review will be discussed with Executive Director or their designee at weekly management meeting, to ensure compliance with TB testing. 5) By what date the systemic changes will be completed: Date of Completion: 7/25/14	

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	test prior to or upon admission to the facility. 3. Resident #59's record was reviewed on 6/4/14 at 12:13 P.M. Diagnoses included, but were not limited to, dementia, atrial fibrillation, hypertension, anemia and mitral regurgitation. The resident's "Facesheet" indicated the resident was admitted to the facility on 3/31/14. The "Resident TB/Immunization Record" was not located in the resident's record. The resident's record lacked documentation that a first and/or second step tuberculin skin test had been placed prior to or after admission. During an interview on 6/5/14 at 9:10 A.M., the RCD indicated the resident had her first step tuberculin skin test at the transferring facility, but she did not receive her second step tuberculin skin test after she arrived at this facility. She indicated her first and second step tuberculin skin tests were being re-administered as of today.			